STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION

42 CFR 447.201 — Medical and Remedial Care and Services
Item 6.d. (cont.)

C. Remaining minutes are divided by five (5) to arrive at the number of additional intervals to be reimbursed. Remaining minutes after these calculations that are less than five (5) minutes are not reimbursed. Reimbursement for five (5) minute intervals shall be as follows:

Unit Time	Coefficient	Rate
15 min.	$15.00	$5.00
15 min.	8.49	2.83
30 min.	15.00	2.50

D. Reimbursement to CRNAs is made at two levels differentiated by whether the CRNA is personally medically directed by an anesthesiologist or works independently of an anesthesiologist. The coefficient is $8.49 for a personally medically directed CRNA (designated by modifier AH) and $15.00 for a nonmedically directed CRNA (designated by modifier AI). The payment is as follows:

1. Modifier AH - Base units plus time units (1 = 15 minutes) multiplied by $8.49 equals payment.

2. Modifier AI - Base units plus time units (1 = 15 minutes) multiplied by $15.00 equals payment.

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CITATION

42 CFR 447.201 — Medical and Remedial Care and Services, Item 6.d. (cont.)

E. Reimbursement to anesthesiologists is made utilizing the coefficient of $15.00 with a percentage reduction of the base units applied according to the number of CRNAs being personally medically directed by the anesthesiologist during the performance of anesthesia services.

Payment will be computed using the following modifiers and formula:

1. Modifier AA - Anesthesiologist working alone - Base units plus time units (1 = 15 minutes) multiplied by $15.00 equals payment.

2. Modifier AB - Direction of two CRNAs - Base units minus 10% + time units (1 = 30 minutes) multiplied by $15.00 equals payment.

3. Modifier AC - Direction of three CRNAs - Base units minus 25% + time units (1 = 30 minutes) multiplied by $15.00 equals payment.

4. Modifier AD - Direction of four or more CRNAs - Base units minus 40% + time units (1 = 30 minutes) multiplied by $15.00 equals payment.

An anesthesiologist may bill for personal medical direction only when two or more anesthesia services are being performed concurrently.

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CITATION

42 CFR 447.201 — Medical and Remedial Care and Services
Item 6.d. (cont.)

F. When an anesthesiologist and a CRNA are both involved in the performance of a single anesthesia service, the service shall be reimbursed based on the consideration that it was performed by the anesthesiologist and no separate payment will be made to the CRNA.

G. Surgeons shall not be reimbursed for the personal medical direction of a CRNA. The anesthesia service will be considered nonmedically directed and should be billed as such by the CRNA.

H. The following CPT-4 procedure codes shall be reimbursed on a flat fee basis (based on the same methodology used for establishing physician fees in Attachment 4.19-B, Item 5) and do not require modifiers or minutes when billed.

36000	36490*	62274
36010*	36491*	62276
36405	36500	62278
36420*	36600	62279
36425*	36620	62282*
36430	36625*	62284*
36640*	36640	62289*
36470*	62270	62290*
36471*	62273	62291*
		62292*

*Under the State Nursing Practice Act these procedures may not be performed by a CRNA and therefore are not reimbursable to CRNAs.

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CITATION

42 CFR 447.201 — Medical and Remedial Care and Services
Item 6.d. (cont.)

I. Maternity Related Anesthesia Services

Maternity related anesthesia services will be reimbursed on a flat fee basis at three levels differentiated by who personally administers the anesthesia - the anesthesiologist, the CRNA, or the surgeon/delivering physician. The only exception is general anesthesia for vaginal delivery which will continue to be reimbursed according to base and time units. The flat fee will be paid in accordance with the CPT-4 procedure code and applicable modifier for both vaginal and cesarean deliveries.

The surgeon or delivering physician will be reimbursed when he initiates the epidural procedure with inclusion of the appropriate procedure code modifier.

The anesthesiologist or CRNA who is called in to continue administering the anesthesia after the epidural was inserted will be reimbursed for the continued administration of the anesthesia with inclusion of the appropriate modifier. Anesthesia and operative reports must substantiate the modifier utilized.

Anesthesiologists and/or CRNAs may not bill for both continued administration and general anesthesia.

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CITATION

42 CFR 447.201 Medical and Remedial Care and Services
Item 6.d. (cont.)

II. Standards for Payment

A. Anesthesiologist means a physician licensed by the Louisiana State Board of Medical Examiners and currently certified by the American College of Anesthesiology.

B. Certified registered nurse anesthetist (CRNA) means a person who:

1. is a registered nurse licensed by the Louisiana State Board of Nursing;

2. has met any other Louisiana licensure requirements applicable to nonphysician anesthetists; and

3. is currently certified by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.

C. Anesthesiologists and certified registered nurse anesthetists must be enrolled as Medicaid providers in order to be directly reimbursed for their services.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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CITATION	Medical and Remedial Care and Services	Audiologists
42 CFR 447.200-205	Item 6.d.	

I. Method of Payment

Audiologists are reimbursed under the same methodology used to reimburse physician providers.

II. Standards for Payment

An audiologist must obtain a referral for audiology services from a licensed physician.

Audiologists are reimbursed for the Physicians' Current Procedural Terminology (CPT) codes currently approved for the reimbursement of audiology services to physicians and in accordance with the current regulations of the Physician Program.

Reimbursement is made at the lower of:

A. the provider's billed charge for the services or

B. the maximum allowable fee for audiology services covered under the Medical Assistance Program's provider reimbursement fee schedule.

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CITATION	Medical and Remedial
42 CFR	Care and Services
447.201	Item 7.
447.304	

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Home Health Care Services

Item 7.a. Intermittent or part-time nursing service provided by a home health agency

Item 7.b. Home Health aide services provided by a home health agency

Item 7.c. Medical supplies, equipment and appliances suitable for use in the home

Item 7.d. Rehabilitation services provided by a home health agency.

I. Method of Payment

A. Intermittent or Part-time Nursing Service provided by a home health agency and for Home Health Aide Services provided by a home health agency will be reimbursed using a prospective payment methodology based on the audited 1992 cost reports at the weighted thirtieth (30th) percentile based on cost and number of services trended forward at July 1 of each preceding year using the Consumer Price Index - All Urban Consumers (Southern Region).

B. Rehabilitation Services provided by a home health agency will be reimbursed using a prospective payment methodology based on the audited 1992 cost reports at the weighted twentieth (20th) percentile based on cost and number of services trended forward at July 1 of each preceding year using the Consumer Price Index - All Urban Consumers (Southern Region).

II. Standards for Payment

A. For items 7.a., 7.b., 7.c., 7.d., see Attachment 3.1-C regarding standards and methods of assuring high quality care.

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B. 1. For appliances and equipment, see Medical and Remedial Care and Services, Item 12.c. Attachment 4.19-B.

2. For medically necessary Medical Supplies, Equipment and Appliances reimbursement will be made through the Durable Medical Equipment Program which requires prior authorization for the item. Items may be authorized to existing durable medical equipment providers or to home health agencies which enroll as durable medical equipment providers.

a. Diapers and blue pads are not reimbursable as durable medical equipment items.

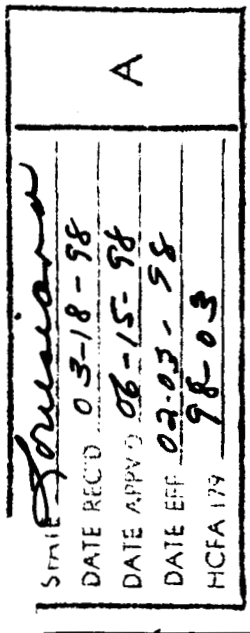
b. Certain supplies for wound care and dressing will be covered under the Durable Medical Equipment Program but will be authorized exclusively for the use of home health agencies when delivering home health services.

C. "Home Health Care Agency" means a public or private agency which is licensed by DHH, Bureau of Health Services Financing, Health Standards Section, and qualified to participate as a home health agency under Title XVIII of the Social Security Act, and is determined currently to meet the requirements for Title XIX participation.

Home Health Agencies conform to Section 4724 (b) of the Balanced Budget Act '97 and P. L. 105-33.

"Home Health Care and Services" are provided on the basis of a treatment plan as certified by a licensed and appropriate physician to a patient in his place of residence, but not including as a residence a hospital or skilled nursing facility. However, rehabilitation services may be provided by a home health agency in an Intermediate Care Facility I or II when a Title XIX recipient who is admitted or retained by the facility is in need of such services. A written agreement must be executed between the facility and the home health agency for the provision of these services.

All written plans of care must be on file at the home health agency and reviewed by the physician every sixty (60) days.



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D. Medical Necessity Criteria for Medicaid Recipients

The Bureau will provide reimbursement for approved home health services for Medicaid recipients based upon the certification of a licensed physician and a determination by the Medicaid agency that the recipient meets the medical necessity criteria outlined in Attachment 3.1-A, Item 7.I.B.

E. The responsibilities of the home health agency:

1. The home health agency must provide to the Bureau upon request the supporting documentation used to determine the recipient's homebound status.

2. The home health agency must report a complaint of abuse or neglect of home health recipient(s) to the appropriate authorities if the agency has knowledge that a minor child, or a non-consenting adult or mentally incompetent adult, has been abused or not receiving the proper medical care due to neglect or lack of cooperation on the part of the legal guardians or caretakers. This includes knowledge that a patient is routinely being taken out of the home by a legal guardian or caretaker against medical advise, or when it is obviously medically contraindicated.

3. Physicians with a significant interest in or relationship with a home health agency are prohibited from preparing a certification of need for home health agency services or establishment and review of a plan of treatment for such services for the home health agency.

   a. Significant financial or contractual relationship means a relationship that involves direct or indirect business transactions that, in any fiscal year, amount to more than $25,000 or 5 per cent of the agency's total operating expenses, whichever is less.

   b. Business transactions mean contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, and space; and

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c. A physician will be considered to have a "significant ownership interest" if he or she -

(1) has a direct or indirect ownership interest of 5 per cent or more in the capital, the stock, or the profits of the home health agency;

has an ownership interest of 5 per cent or more in any mortgage, deed of trust, note, or other obligation that is secured by the agency, if that interest equals 5 per cent or more of the agency's assets; or

(3) is an officer or director of a home health agency organiz ed as a corporation, or a partner in a organized as a partnership.

4. Nurses. Nurses (LPNs and Rns) must be currently licensed by the Louisiana State Board of Nurse Examiners.

5. Home Health Aides. The plan of treatment to be provided by a home health aide must be outlined by the attending physician and home health agency, which assigns a professional registered nurse to provide continuing supervision of the aide.

6. Physical Therapist. Must be qualified physical therapists. See amount, duration and scope of medical and remedial care and services provided, Attachment 3.1 A, Item 7.d.

7. Utilization Review. Each participating home health agency is required to have an in-house utilization review committee, or U/R procedures in place.

8. The home health agency is required to instruct the families on non-complex physical therapy tasks when feasible.